The McBride Commission Report

Submitted to the Honorable
Mel Carnahan
Governor, State of Missouri

September 1995

Pursuant to the
Executive Order 95-09

THE MCBRIDE COMMISSION

A Study of Missouri's Civil Detention Procedures

September 29, 1995

The Honorable Mel Carnahan
Governor of Missouri
State Capitol, Room 216
Jefferson City, MO 65102

Dear Governor Carnahan:

Embracing your belief that Missourians must be free to live their lives and pursue their dreams beyond the limitations of mental illness and acknowledging your realization that Missourians need access to effective mental health services in times of crisis, your McBride Commission, an inter-disciplinary, consumer orientated panel, is pleased to submit this report. We believe it meets your original charge to us -- to make recommendations for enhancing Missouri's mental health care services delivery system and our state's civil involuntary mental health treatment laws.

Sincerely,

Lori DeRosear, D.O.
Chairperson

1706 East Elm St. • Jefferson City, Missouri • 65101 • 314-751-8091

WHEREAS, Missourians must be free to live their lives and pursue their dreams beyond the limitation of mental illness; and

WHEREAS, Missourians need access to effective mental health services in times of crisis; and

WHEREAS, the State of Missouri should facilitate the delivery of needed mental health services; and

WHEREAS, the legacy James and Nancy McBride have left to Missouri is one of service and assistance to persons with mental health needs; and

WHEREAS, Mark, Lisa and James McBride seek to carry on their parents' spirit of service;

NOW, THEREFORE, I, Mel Carnahan, Governor of the State of Missouri, by virtue of the authority vested in me by the Constitution and laws of the State of Missouri, do hereby establish the McBride Commission to review the civil involuntary mental health treatment laws of the State of Missouri. No later than September of 1995, the Commission shall recommend to the Governor enhancements to the civil involuntary mental health treatment laws of Missouri, including the form in which the State should adopt the concept of "grave disability" as the basis for involuntary mental health treatment, and the circumstances under which outpatient involuntary mental health treatment should be mandated. These recommendations shall be made in the context of ensuring that persons with mental illness and their caregivers have effective and rapid access to mental health services needed in times of crisis.

The McBride Commission shall be comprised of the following nineteen members appointed by the Governor:

A chairperson who is a mental health care clinician possessing significant experience in civil commitment practices;

One representative who possesses significant knowledge of civil commitment practices and laws nationally;

Three primary mental health consumers of whom at least one is a member of the Missouri Mental Health Consumer Network and at least one is a member of the Missouri Coalition of Alliances for the Mentally Ill;

Two secondary mental health consumers of whom at least one is a member of the Missouri Coalition of Alliances for the Mentally Ill;

One representative from the Missouri Advisory Council for Comprehensive Psychiatric Services;

One representative from the Missouri Advisory Council on Alcohol and Drug Abuse;

One representative from Missouri Protection and Advocacy Services;

One representative from the Coalition of Community Mental Health Centers;

One representative from the Missouri Sheriff's Association;

One representative from the Missouri Hospital Association;

One representative from the Missouri Association of Prosecuting Attorneys;

One representative from Legal Aid Services;

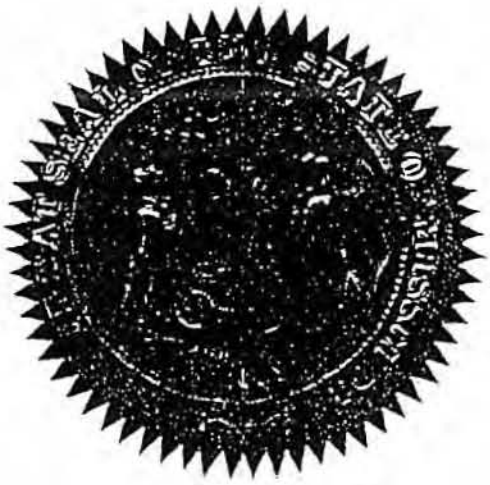
One representative from the Missouri Association of Psychosocial Rehabilitation Services-Places for People;

One representative from the Missouri Association of Public Administrators;

One representative from the Missouri Bar Association -- Probate Section; and

One representative from the Missouri Probate Judges.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 3rd day of March, 1995.



Mel Carnahan
GOVERNOR

ATTEST:

Rebecca McDowell Cook
SECRETARY OF STATE

Table of Contents

Executive Summary of the McBride Commission Report

Executive Order 95-09

INTRODUCTION

On March 3, 1995, Governor Mel Carnahan established the McBride Commission. The Governor asked the 19-member Commission to recommend enhancements to civil involuntary treatment laws as well as circumstances under which outpatient involuntary mental health treatment should be mandated. The Governor also mandated that "these recommendations shall be made in the context of ensuring that persons with mental illness and their caregivers have effective and rapid access to mental health services needed in times of crisis."

In preparation for its mission, the Commission studied topical literature, research findings, mental health statutes and case law. It also consulted other experts in the field of mental health. It held six two-day public meetings as well as numerous subcommittee and work group meetings. It held eight public hearings, allowing Missourians from throughout the state an opportunity to provide testimony and comment.

SUMMARY FINDINGS AND RECOMMENDATIONS

After extensive review, study and deliberation and in consideration of public comment, the Commission makes the following findings and recommendations:

FINDING 1: Under Constitutional rulings, current involuntary treatment laws provide an adequate, but often misperceived and misapplied, general framework for civil involuntary inpatient treatment of persons with mental illness.

RECOMMENDATION: The Commission recommends changes and clarifications to current statutory language and definitions as well as adding a vehicle to use outpatient detention and treatment. See, for example, the recommendations regarding Sections 632.005 (9) and 632.330. See also the Report of the Commission in Chapter 2 relating to education.

FINDING 2: Interpretation of laws varies considerably among mental health professionals, peace officers, attorneys and judges, and by region, within agencies and among the general public. The concept of "gravely disabled" exists in current statute, but recognition of that concept is not generally accepted in the judicial and professional communities. Thus, the concept of "gravely disabled" is not available to all persons as a basis for civil involuntary treatment.

RECOMMENDATION: The Commission believes that adding another statutory term ("gravely disabled") only would cause further confusion. However, it recommends changes to current statutory language to clarify the concept of "harm" and emphasizes the use of guardianship as an to alternative to civil commitment. See the recommendations in Chapter 1 regarding Sections 632.005(9) and 632.330.3 and .4.

FINDING 3: Resources for treating persons with mental illness vary throughout the state. Yet, availability of resources is crucial in effecting the parens patriae purpose of the statute. For example, limited community treatment options inhibit early access to services, a time when success rates are highest. Leaving people without early treatment results in escalation of their problems to the point at which involuntary treatment is necessary.

RECOMMENDATION: The Commission recommends changes to current statutes and the addition of two new statutory provisions. See the recommendations in Chapter 1 regarding Sections 632.055, 632.337 and 632.393. Also see the Commission's Report in Chapter 3 for its discussion of services and supports.

FINDING 4: Guardianship is important for some persons with mental illness. However, the public administrator system, which serves significant numbers of incapacitated persons with mental illness, is underfunded and burdened with large case loads.

RECOMMENDATION: The Commission recommends that the Governor appoint a separate commission to study and make recommendations for enhancing the public administration system.

FINDING 5: Current client rights protections in Missouri's mental health code apply only to persons admitted to facilities and programs operated, funded or licensed by the Department of Mental Health. Yet, more and more persons with mental health care service needs receive help through private programs and facilities. Moreover, with an increasing emphasis on delivering services through managed care, it is likely that more persons with mental illness will be receiving services through private programs funded with state Medicaid dollars. Finally, effects of the ruling in State v. Dale, 775 S.W.2d 126 (MO 1989), which prevents enforcement of the abuse and neglect statute, and Bonds v. Department of Mental Health, 887 S.W.2d 418 (Mo. App. 1994), which prevents enforcement of certain client rights protections, must be considered.

RECOMMENDATION: The Commission recommends that various client rights statutes be enhanced, especially that their coverage be expanded. See the recommendations in Chapter 1 regarding Sections 630.110, 630.115, 630.155, and 630.175.

FINDING 6: The general public, staff of service providers, the legal community, and many peace officers often are unaware of, or are misinformed about, services and treatment options and the laws pertaining to persons with mental illness.

RECOMMENDATION: The Commission recommends two statutory remedies. See the recommendations in Chapter 1 regarding Sections 632.392.1 (1) and 632.393. In addition, the Commission unanimously urges the design and implementation of an educational campaign to reach mental health professionals, peace officers, consumers, the bench, the bar and the general public. See Chapter 2 of the Commission's Report.

FINDING 7: Because the private and public mental health care service delivery systems generally operate independently and under separate statutory provisions, there is a lack of consistency concerning delivery of services and client rights protections.

RECOMMENDATION: The Commission recommends statutory revisions as set out in Section 632.330 of Chapter 1 and, in Appendix B, offers its Resolution and Policy Statement on Medicaid Managed Care, which is related to responsibilities of private health care organizations acting as part of the service delivery system for persons who are civilly detained. Also see Chapter 2 of the Commission's Report regarding education and statutory changes to extend client rights protections to persons admitted to private facilities. Also, see the recommendation for Finding 5.

FINDING 8: Because of a shortage of resources, not enough services are available to persons with mental illness, particularly crisis intervention for all persons with mental illness and those core services the Commission believes are essential for all clients of the Department's Division of Comprehensive Psychiatric Services. Because of this shortage, the Department of Mental Health has targeted its limited resources to persons with serious and persistent mental illness. Consequently, persons whose mental illness is less serious have more difficulty obtaining care, and their treatment choices, including rehabilitation, are limited and more expensive. Also, provider options are narrowed if treatment is delayed until crises occur.

RECOMMENDATION: The Commission's recommendation on services and supports is in its report in Chapter 3. Also, in Chapter 1, see the recommended changes to Section 632.055 and the recommended additional Section 632.393.

FINDING 9: It is unclear whether Missouri statutes provide authority for persons to make advance directives regarding their psychiatric health care.

RECOMMENDATION: The Commission recommends that the Governor appoint a separate commission to study the possible adoption and use of mental health advanced directives in Missouri. See the Commission's Resolution and Policy Statement on Advance Directives in Appendix A.

FINDING 10: In cases of civil commitment and guardianship, many persons with mental disorders are unable to get to treatment because persons who might provide transportation to that treatment have concerns over their liability in these circumstances.

RECOMMENDATION: The Commission recommends two changes and one new statutory provision to address this problem. See the Commission's changes to Sections 632.337.1, 632.440 and the recommended additional Section 475.124 in Chapter 1.

FINDING 11: Consumers are a powerful but underused resource in their own recovery as well as the recovery of other consumers. These consumers are valuable members of their communities when they have effective and timely treatment, adequate support, housing and jobs.

RECOMMENDATION: The Commission's report on services and supports is in Chapter 3.

FINDING 12: After discharge from mental health facilities, some persons with mental illness need assistance from care providers who are responsible for the persons' health care and treatment. These care providers are often unable to provide required support because of statutory restrictions on access to client information. Providing certain client information to care providers would improve the clients' mental health care and treatment and help to ensure client and public safety.

RECOMMENDATION: The Commission recommends addition of a statutory provision to permit providing medically necessary client information to caregivers who need it to benefit clients in their care. See the recommendations in Chapter 1 regarding Section 632.392.

CHAPTER

1

McBride Commission

Recommended Statutory Revisions

Note: The language in the box following each statutory recommendation contains the commission's rationale for that recommendation.

630.005. 1. As used in chapters 630, 631, 632, and 633, RSMo, unless the context clearly requires otherwise, the following terms shall mean:

(1) "Administrative entity," a provider of specialized services other than transportation to clients of the department on behalf of a division of the department;

(2) "Alcohol abuse," the use of any alcoholic beverage, which use results in intoxication or in a psychological or physiological dependency from continued use, which dependency induces a mental, emotional or physical impairment and which causes socially dysfunctional behavior;

(3) "Chemical restraint," medication administered with the primary intent of restraining a patient who presents a likelihood of serious physical injury to himself or others, and not prescribed to treat a person's medical condition;

(4) "Client," any person who is placed by the department in a facility or program licensed and funded by the department or who is a recipient of services from a regional center, as defined in section 633.006, RSMo;

(5) "Commission," the state mental health commission;

(6) "Consumer," a person:

(a) Who qualifies to receive department services; or

(b) Who is a parent, child or sibling of a person who receives department services; or

(c) Who has a personal interest in services provided by the department.

A person who provides services to persons affected by mental retardation, developmental disabilities, mental disorders, mental illness, or alcohol or drug abuse shall not be considered a consumer;

(7) "Day program," a place conducted or maintained by any person who advertises or holds himself out as providing prevention, evaluation, treatment, habilitation or rehabilitation for persons affected by mental disorders, mental illness, mental retardation, developmental disabilities or alcohol or drug abuse for less than the full twenty-four hours comprising each daily period;

(8) "Department," the department of mental health of the state of Missouri;

(9) "Developmental disability," a disability:

(a) Which is attributable to:

a. Mental retardation, cerebral palsy, epilepsy, head injury or autism, or a learning disability related to a brain dysfunction; or

b. Any other mental or physical impairment or combination of mental or physical impairments; and

(b) Is manifested before the person attains age twenty-two; and

(c) Is likely to continue indefinitely; and

(d) Results in substantial functional limitations in two or more of the following areas of major life activities:

a. Self-care;

b. Receptive and expressive language development and use;

c. Learning;

d. Self-direction;

e. Capacity for independent living or economic self-sufficiency;

f. Mobility; and

(e) Reflects the person's need for a combination and sequence of special, interdisciplinary, or genetic care, habilitation or other services which may be of lifelong or extended duration and are individually planned and coordinated;

(10) "Director," the director of the department of mental health, or his designee;

(11) "Domiciled in Missouri," a permanent connection between an individual and the state of Missouri, which is more than mere residence in the state; it may be established by the individual being physically present in Missouri with the intention to abandon his previous domicile and to remain in Missouri permanently or indefinitely;

(12) "Drug abuse," the use of any drug without compelling medical reason, which use results in a temporary mental, emotional or physical impairment and causes socially dysfunctional behavior, or in psychological or physiological dependency resulting from continued use, which dependency induces a mental, emotional or physical impairment and causes socially dysfunctional behavior;

(13) "Habilitation," a process of treatment, training, care or specialized attention which seeks to enhance and maximize the mentally retarded or developmentally disabled person's abilities to cope with the environment and to live as normally as possible;

(14) "Habilitation center," a residential facility operated by the department and serving only persons who are mentally retarded, including developmentally disabled;

(15) "Head of the facility," the chief administrative officer, or his designee, of any residential facility;

(16) "Head of the program," the chief administrative officer, or his designee, of any day program;

(17) "Individualized habilitation plan," a document which sets forth habilitation goals and objectives for mentally retarded or developmentally disabled residents and clients, and which details the habilitation program as required by law, rules and funding sources;

(18) "Individualized rehabilitation plan," a document which sets forth the care, treatment and rehabilitation goals and objectives for patients and clients affected by alcohol or drug abuse, and which details the rehabilitation program as required by law, rules and funding sources;

(19) "Individualized treatment plan," a document which sets forth the care, treatment and rehabilitation goals and objectives for mentally disordered or mentally ill patients and clients, and which details the treatment program as required by law, rules and funding sources;

(20) "Investigator," an employee or contract agent of the department of mental health who is performing an investigation regarding an allegation of abuse or neglect or an investigation at the request of the director of the department of mental health or his designee;

(21) "Least restrictive environment," a reasonably available setting or **mental health program** where care, treatment, habilitation or rehabilitation is particularly suited to the level and quality of services necessary to implement a person's individualized treatment, habilitation or rehabilitation plan and to enable the person to maximize his functioning potential to participate as freely as feasible in normal living activities, giving due consideration to potentially harmful effects on the person. For some mentally disordered or mentally retarded persons, the least restrictive environment may be a facility operated by the department[.], **a private facility or supported community living situations and alternative community programs designed for persons who are civilly detained for outpatient treatment or are conditionally released pursuant to chapter 632, RSMo;**

(22) "Mental disorder," any organic, mental or emotional impairment which has substantial adverse effects on a person's cognitive, volitional or emotional function and which constitutes a substantial impairment in a person's ability to participate in activities of normal living;

(23) "Mental illness," a state of impaired mental processes, which impairment results in a distortion of a person's capacity to recognize reality due to hallucinations, delusions, faulty perceptions or alterations of mood, and interferes with an individual's ability to reason, understand or exercise conscious control over his actions. The term "mental illness" does not include the following conditions unless they are accompanied by a mental illness as otherwise defined in this subdivision:

(a) Mental retardation, developmental disability or narcolepsy;

(b) Simple intoxication caused by substances such as alcohol and drugs;

(c) Dependence upon or addiction to any substances such as alcohol and drugs;

(d) Any other disorders such as senility, which are not of an actively psychotic nature;

(24) "Mental retardation," significantly subaverage general intellectual functioning which:

(a) Originates before age eighteen; and

(b) Is associated with a significant impairment in adaptive behavior;

(25) "Minor," any person under the age of eighteen years;

(26) "Patient," an individual under observation, care, treatment or rehabilitation by any hospital or other mental health facility **or mental health program** pursuant to the provisions of chapter 632, RSMo;

(27) "Psychosurgery,"

(a) Surgery on the normal brain tissue of an individual not suffering from physical disease for the purpose of changing or controlling behavior; or

(b) Surgery on diseased brain tissue of an individual if the sole object of the surgery is to control, change or affect behavioral disturbances, except seizure disorders;

(28) "Rehabilitation," a process of restoration of a person's ability to attain or maintain normal or optimum health or constructive activity through care, treatment, training, counseling or specialized attention;

(29) "Residence," the place where the patient has last generally lodged prior to admission or, in case of a minor, where his family has so lodged; except, that admission or detention in any facility of the department shall not be deemed an absence from the place of residence and shall not constitute a change in residence;

(30) "Resident," a person receiving residential services from a facility, other than mental health facility, operated, funded or licensed by the department;

(31) "Residential facility," any premises where residential prevention, evaluation, care, treatment, habilitation or rehabilitation is provided for persons affected by mental disorders, mental illness, mental retardation, developmental disabilities or alcohol or drug abuse; except the person's dwelling;

(32) "Specialized service," an entity which provides prevention, evaluation, transportation, care, treatment, habilitation or rehabilitation services to persons affected by mental disorders, mental illness, mental retardation, developmental disabilities or alcohol or drug abuse;

(33) "Vendor," a person or entity under contract with the department, other than as a department employee, who provides services to patients, residents or clients.

630.005.1(21) and (26) In light of the recommendation that the Commission makes in Section 632.005 to add "mental health program" as a legal term of art, it recommends use of the terms "program" and "mental health program" in these paragraphs.

630.005.1(21) Additional language at the end of the definition of "least restrictive environment" relates to the Commission's recommendation that in Chapter 632, a statutory framework be adopted for outpatient commitment to a community setting.

630.110. 1. Each person admitted to a residential facility or day program [operated, funded or licensed by the department,] **and each person admitted on a voluntary or involuntary basis to any mental health facility or mental health program where people are civilly detained pursuant to Chapter 632, RSMo**, except to the extent that the head of the residential facility or day program determines that it is inconsistent with the person's therapeutic care, treatment, habilitation or rehabilitation, shall be entitled to the following:

(1) To wear his own clothes and to keep and use his own personal possessions;

(2) To keep and be allowed to spend a reasonable sum of his own money for canteen expenses and small purchases;

(3) To communicate by sealed mail or otherwise with persons including agencies inside or outside the facility;
(4) To receive visitors of his own choosing at reasonable times;
(5) To have reasonable access to a telephone both to make and receive confidential calls;
(6) To have access to his mental and medical records;
(7) To have opportunities for physical exercise and outdoor recreation;
(8) To have reasonable, prompt access to current newspapers, magazines and radio and television programming.

2. Any limitations imposed by the head of the residential facility or day program or his designee on the exercise of the rights enumerated in subsection 1 of this section by a patient, resident or client and the reasons for such limitations shall be documented in his clinical record.

3. Each patient, resident or client shall have an absolute right to receive visits from his attorney, physician or clergyman, in private, at reasonable times.

4. Notwithstanding any limitations authorized under this section on the right of communication, every patient, resident or client shall be entitled to communicate by sealed mail with the department, his legal counsel and with the court, if any, which has jurisdiction over the person.

630.110.1 The language recommended by the Commission reflects its intent that the rights of persons in private mental health facilities or programs should be protected whether or not the facilities or programs are operated, funded or licensed by the Department of Mental Health.

630.115. 1. Each patient, resident or client shall be entitled to the following without limitation:
(1) To humane care and treatment;
(2) To the extent that the facilities, equipment and personnel are available, to medical care and treatment in accordance with the highest standards accepted in medical practice;
(3) To safe and sanitary housing;
(4) To not participate in nontherapeutic labor;
(5) To attend or not attend religious services;
(6) To receive prompt evaluation and care, treatment, habilitation or rehabilitation about which he is informed insofar as he is capable of understanding;
(7) To be treated with dignity as a human being;
(8) To not be the subject of experimental research without his prior written and informed consent or that of his parent, if a minor, or his guardian; except that no involuntary patient shall be subject to experimental research;
(9) To have access to consultation with a private physician at his own expense;
(10) To be evaluated, treated or habilitated in the least restrictive environment;

(11) To not be subjected to any hazardous treatment or surgical procedure unless he, his parent, if he is a minor, or his guardian consents; or unless such treatment or surgical procedure is ordered by a court of competent jurisdiction;

(12) In the case of hazardous treatment or irreversible surgical procedures, to have, upon request, an impartial review prior to implementation, except in case of emergency procedures required for the preservation of his life;

(13) To a nourishing, well-balanced and varied diet;

(14) To be free from verbal and physical abuse.

2. Notwithstanding any other sections of this chapter, each patient, resident or client shall have the right to an impartial **administrative** review of alleged violations of the rights assured under this chapter. **The impartial administrative review process shall include —**

(1) The opportunity for the patient, resident or client to present information about the alleged violation to an impartial reviewer or panel, appointed by the head of the facility or program. The reviewer or panel shall complete its review within seven days after receiving the information about the alleged violation and may recommend to the head of the facility or program the remediation of any violation of the patient's, resident's or client's rights;

(2) The opportunity for the patient, resident or client to present on the record to the reviewer or panel his grievance and other pertinent information. The concerned facility, program and staff member implicated by the grievance also shall have an opportunity to respond on the record to the grievance;

(3) Copies of the reviewer's or panel's written findings, conclusions and recommendations provided to the patient, resident, or client and the facility or program; and

(4) The written findings, conclusions, and any remediation directed by the head of the facility or program provided to the patient, resident or client, made a permanent part of the patient's, resident's or client's medical record and kept as a permanent part of the administrative record of the facility or program.

3. This impartial review process shall not apply to investigations of alleged patient, resident or client mistreatment, abuse or neglect conducted pursuant to section 630.167.

630.115.2 In light of the decision in *Bonds v. Missouri Department of Mental Health*, 887 S.W.2d 418 (Mo. App. 1994), the Commission recommends that language be added to establish a structured administrative review process for reviewing alleged violations of client rights other than mistreatment, abuse or neglect. Allegations of mistreatment, abuse and neglect are investigated pursuant to a separate statutory section.

630.125.1. At the time of admission, either on a voluntary or involuntary basis, **a mental health facility or mental health program in which people may be civilly detained pursuant to Chapter 632, RSMo, or** a residential facility or day program operated, funded, or licensed by the department shall give each patient, resident or client written information which sets forth, in lay language, the following:

(1) A description of the facility, its services and its costs;

(2) Information as to how to seek conditional release or discharge;

(3) A statement of rights assured by this chapter or the department in its rules and regulations;

(4) A description of a patient grievance procedure.

2. Unless the patient, resident or client can read the information with understanding, the facility personnel shall explain it to him.

3. The facility or program shall prominently post a list of patient or residential rights in residential and activity areas.

630.125.1 See the note related to Section 630.110.1.

630.130.1. Every patient, whether voluntary or involuntary, in a public or private mental health facility shall have the right to refuse electroconvulsive therapy.

2. Before electroconvulsive therapy may be administered voluntarily to a patient, the patient shall be informed, both orally and in writing, of the risks of the therapy and shall give his express written voluntary consent to receiving the therapy.

3. Involuntary electroconvulsive therapy may be administered under a court order after a full evidentiary hearing where the patient refusing such treatment is represented by counsel who shall advocate his position. The therapy may be administered on an involuntary basis only if it is shown, by clear and convincing evidence, that the therapy is necessary under the following criteria:

(1) There is a strong likelihood that the therapy will significantly improve or cure the patient's mental disorder for a substantial period of time without causing him any serious functional harm; and

(2) There is no less drastic alternative form of therapy which could lead to substantial improvement in the patient's condition.

(3) At the conclusion of such hearing, if the petitioner has sustained his burden of proof, the court may order up to a specified number of involuntary electroconvulsive therapy treatments to be performed over a specified period of time.

(4) Parents of minor patients or legal guardians of **[**incompetent**]** **incapacitated** patients shall be required to obtain court orders authorizing electroconvulsive therapy under the procedures specified in subsection 3 of the section.

(5) Persons who are diagnosed solely as mentally retarded shall not be subject to electroconvulsive therapy.

630.133.1. Psychosurgery shall not be performed involuntarily on any patient or resident. A competent patient or resident shall be informed, both orally and in writing, of the risks of the therapy and shall give his express written voluntary consent before the surgery is performed. Parents of minor patients or residents or legal guardians of **[**incompetent**]** **incapacitated** patients or residents shall be required to obtain court orders authorizing such surgery under the procedures and criteria specified in subsection 3 of §630.130.

2. Psychosurgery shall not be performed by the department in any of its facilities.

;

630.133 The Commission recommends this amendment to comport with changes previously adopted within the guardianship code.

630.140.1. Information and records compiled, obtained, prepared or maintained by the residential facility **[**or**]**, day program operated, funded or licensed by the department or otherwise, **specialized service, or by any mental health facility or mental health program in which people may be civilly detained pursuant to Chapter 632, RSMo,** in the course of providing services to either voluntary or involuntary patients, residents, or clients shall be confidential.

2. The facilities or programs shall disclose information and records to the following upon their request:

(1) The parent of a minor patient, resident or client;

(2) The guardian or other person having legal custody of the patient, resident or client;

(3) The attorney of a patient, resident or client who is a ward of the juvenile court, an alleged incompetent, an incompetent ward or a person detained under chapter 632, RSMo, as evidenced by court orders of the attorney's appointment;

(4) An attorney or personal physician as authorized by the patient, resident or client;

(5) The entity or agency authorized to implement a system to protect and advocate the rights of persons with developmental disabilities under the provisions of 42 USC 6042. The entity or agency shall be able to obtain access to the records of a person with developmental disabilities who is a client of the entity or agency if such person has authorized the entity or agency to have such access; and the records of any person with developmental disabilities who, by reason of mental or physical condition is unable to authorize the entity or agency to have such access, if such person does not have legal a guardian, conservator or other legal representative, and a complaint has been received by the entity or agency with respect to such person or there is probable cause to believe that such person has been subject to abuse or neglect. The entity or

agency obtaining access to a person's records shall meet all requirements for confidentiality as set out in this section;

(6) The entity or agency authorized to implement a system to protect and advocate the rights of persons with mental illness under the provisions of 42 USC 10801 shall be able to obtain access to the records of a patient, resident or client who by reason of mental or physical condition is unable to authorize the system to have such access, who does not have a legal guardian, conservator or other legal representative and with respect to whom a complaint has been received by the system or there is probable cause to believe that such individual has been subject to abuse or neglect. The entity or agency obtaining access to a person's records shall meet all requirements for confidentiality as set out in this section. The provisions of this subdivision shall apply to a person who has a significant mental illness or impairment as determined by a mental health professional qualified under the laws and regulations of the state.

3. The facilities or services may disclose information and records under any of the following:

(1) As authorized by the patient, resident or client;

(2) To persons or agencies responsible for providing health care services to such patients, residents or clients;

(3) To the extent necessary for a recipient to make a claim or for a claim to be made on behalf of a recipient for aid or insurance;

(4) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, program evaluations or similar studies; provided, that such personnel shall not identify, directly or indirectly, any individual patient, resident or client in any report of such research, audit or evaluation, or otherwise disclose patient, resident or client identities in any manner;

(5) To the courts as necessary for the administration of chapter 211, RSMo, 475, RSMo, 522 RSMo, or 632, RSMo;

(6) To law enforcement officers or public health officers, but only to the extent necessary to carry out the responsibilities of their office, and all such law enforcement and public health officers shall be obligated to keep such information confidential;

(7) Pursuant to an order of a court or administrative agency of competent jurisdiction;

(8) To the attorney representing petitioners and to mental health coordinators, but only to the extent necessary to carry out their duties under chapter 632, RSMo;

(9) To the department of social services as necessary to report or have investigated abuse, neglect, or rights violations of patients, residents, or clients;

(10) To a county board established pursuant to sections 205.968 to 205.972, RSMo 1986, but only to the extent necessary to carry out their statutory responsibilities. The county board shall not identify, directly or indirectly, any individual patient, resident or client.

4. The facility or program shall document the dates, nature, purposes and recipients of any records disclosed under this section and sections 630.145 and 630.150.

5. The records and files maintained in any court proceeding under chapter 632, RSMo, shall be confidential and available only to the patient, his attorney, guardian, or, in the case of a minor, to

a parent or other person having legal custody of the patient, and to the petitioner and his attorney. In addition, the court may order the release or use of such records or files only upon good cause shown, and the court may impose such restrictions as the court deems appropriate.

6. Nothing contained in this chapter shall limit the rights of discovery in judicial or administrative procedures as otherwise provided for by statute or rule.
7. The fact of admission of a voluntary or involuntary patient to a mental health facility under chapter 632, RSMo, may only be disclosed as specified in subsections 2 and 3 of this section.

630.140.1 See the note related to Section 630.110.1.

630.155.1. [A person commits the crime of "patient, resident or client abuse" if he does any of the following:] **Mistreatment, abuse or neglect of a patient, resident or client is unlawful and is prohibited. A person violates this prohibition if he does any of the following:**

(1) Purposely beats, strikes, wounds or injures **any person admitted on a voluntary or involuntary basis to any mental health facility or mental health program in which people may be civilly detained pursuant to Chapter 632, RSMo, or** any patient, resident or client of any residential facility, [or] day program **or specialized service**, operated, funded or licensed by the department.

(2) In any manner whatsoever mistreats or maltreats, handles or treats any such patient, resident or client in a brutal or inhumane manner;

(3) In handling such patient, resident, [or] client **or person admitted on a voluntary or involuntary basis to any mental health facility or mental health program in which people may be civilly detained pursuant to Chapter 632, RSMo,** uses any more force than is reasonably [or apparently] necessary for the proper control, treatment or management of such **person**, patient, resident or client;

(4) Fails to provide services which are reasonable and necessary to maintain the physical and mental health of **any person admitted on a voluntary or involuntary basis to any mental health facility or mental health program in which people are civilly detained pursuant to Chapter 632, RSMo,** or of any patient, resident or client of any residential facility [or], day program **or specialized service** operated, funded or licensed by the department, when such failure presents either an imminent danger to the health, safety or welfare of the patient, resident or client, or a substantial probability that death or serious physical harm would result.

2. **Any mistreatment, abuse or neglect of a** [P]patient, resident or client [abuse or neglect] **that is committed knowingly** is a class [A misdemeanor] **D felony**.

630.155.1 and .2. The Commission recommends this language for the following reasons:
1) To reflect its concern for extending protection to persons in private facilities. See the note related to section 630.110.1; and
2) To make section 630.155.2 enforceable in light of the decision in *State v. Dale*, 775 S.W.2d 126 (Mo. 1989).

630.160.1. A person commits the crime of "furnishing unfit food to patients, residents or clients" if he does any of the following:

(1) Knowingly furnishes or delivers any diseased, putrid or otherwise unwholesome meat from any animal or fowl that was diseased or otherwise unfit for food to **any person admitted on a voluntary or involuntary basis to any mental health facility or mental health program in which people may be civilly detained pursuant to Chapter 632, RSMo, or to** any residential facility or day program operated, funded or licensed by the department.;

(2) Knowingly furnishes or delivers any other unwholesome food, vegetables or provisions whatsoever to such facilities **or programs** to be used as food by the patients, residents, clients or employees thereof;

(3) Knowingly receives or consents to receive as an employee of such facility **or program** any diseased or unwholesome meat, food or provisions.

2. Furnishing unfit food to patients, residents or clients is a class A misdemeanor.

630.160.1 See the note related to Section 630.110.1.

630.165.1 When any physician, dentist, chiropractor, optometrist, podiatrist, intern, nurse, medical examiner, social worker, psychologist, minister, Christian Science practitioner, peace officer, pharmacist, physical therapist, facility administrator, nurse's aide or orderly in a residential facility, day program or specialized service operated, funded or licensed by the department **or in a mental health facility or mental health program in which people may be admitted on a voluntary basis or are civilly detained pursuant to Chapter 632, RSMo,** has reasonable cause to believe that a patient, resident or client of a facility, program or service has been **mistreated**, abused or neglected, he shall immediately report or cause a report to be made to the department.

2. The report shall contain the name and address of the residential facility, day program or specialized service; the name of the patient, resident or client; information regarding the nature of the **mistreatment**, abuse or neglect; the name of the complainant, and any other information which might be helpful in an investigation.

3. Any person required in subsection 1 of this section to report or cause a report to be made to the department who fails to do so within a reasonable time after the act of abuse or neglect is guilty of an infraction.
4. In addition to those persons required to report under subsection 1 of this section, any other person having reasonable cause to believe that a resident has been **mistreated**, abused or neglected may report such information to the department.

630.165.1 See the note related to Section 630.110.1.

630.167.1 Upon receipt of a report, the department or its agents, contractors or vendors, shall initiate an investigation within twenty-four hours.

2. If the investigation indicates possible **mistreatment**, abuse or neglect of a patient, resident or client, the investigator shall refer the complaint together with his report to the department director for appropriate action. If, during the investigation or at its completion, the department has reasonable cause to believe that immediate removal from a facility not operated or funded by the department is necessary to protect the residents from **mistreatment**, abuse or neglect, the department or the local prosecuting attorney may, or the attorney general upon request of the department shall, file a petition for temporary care and protection of the residents in a circuit court of competent jurisdiction. The circuit court in which the petition is filed shall have equitable jurisdiction to issue an ex parte order granting the department authority of the temporary care and protection of the resident for a period not to exceed thirty days.
3. (1) Reports shall be confidential, shall not be deemed a public record, and shall not be subject to the provisions of 109.180, RSMo, or chapter 610, RSMo; except that, all such reports shall be open to the parents or other guardian of the patient, resident, or client who is the subject of such report. The name of the complainant or any person mentioned in the reports shall not be disclosed unless such complainant or person specifically requests such disclosure or unless a judicial proceeding results therefrom;

(2) Except as otherwise provided in this section, the proceedings, findings, deliberations, reports and minutes of investigators or of committees of health care professionals as defined in 537.035, RSMo, or mental health professionals as defined in 632.005, RSMo, who have the responsibility to evaluate, maintain, or monitor the quality and utilization of mental health services, or to investigate reports of **mistreatment**, abuse or neglect or incident reports or complaints of substandard, inadequate or inappropriate care are privileged and shall not be subject to the discovery, subpoena or other means of legal compulsion for their release to any person or entity or be admissible into evidence into any judicial or administrative action for failure to provide adequate or appropriate care. Such committees may exist, either within department facilities or its agents, contractors, or vendors, as applicable. Except as otherwise provided in this section,

no person who was in attendance at any investigation or committee proceeding shall be permitted or required to disclose any information acquired in connection with or in the course of such proceeding or to disclose any opinion, recommendation or evaluation of the committee or board or any member thereof; provided, however, that information otherwise discoverable or admissible from original sources is not to be construed as immune from discovery or use in any proceeding merely because it was presented during proceedings before any committee or in the course of any investigation, nor is any member, employee or agent of such committee or other person appearing before it to be prevented from testifying as to matters within their personal knowledge and in accordance with the other provisions of this section, but such witness cannot be questioned about the testimony or other proceedings before any investigation or before any committee;

(3) Nothing in this section shall limit authority otherwise provided by law of a health care licensing board of the State of Missouri to obtain information by subpoena or other authorized process from investigation committees or to require disclosure of otherwise confidential information relating to matters and investigations within the jurisdiction of such health care licensing boards; provided, however, that such information, once obtained by such board and associated persons, shall be governed in accordance with the provisions of this subsection;

(4) Nothing in this section shall limit authority otherwise provided by law in subdivisions (5) and (6) of subsection 2 of 630.140 concerning access to records by the entity or agency authorized to implement a system to protect and advocate the rights of persons with developmental disabilities under the provisions of 42 USC 6042 and the entity or agency authorized to implement a system to protect and advocate the rights of persons with mental illness under the provisions of 42 USC 10801. In addition, nothing in this section shall serve to negate assurances that have been given by the governor of Missouri to the U.S. Administration on Developmental Disabilities, Office of Human Development Services, Department of Health and Human Services concerning access to records by the agency designated as the protection and advocacy system for the State of Missouri. However, such information, once obtained by such entity or agency, shall be governed in accordance with the provisions of this subsection.

4. Anyone who makes a report pursuant to this section or who testifies in any administrative or judicial proceeding arising from the report shall be immune from any civil liability for making such a report or for testifying unless such person acted in bad faith or with malicious purpose.

5. Within five working days after a report required to be made under this section is received, the person making the report shall be notified in writing of its receipt and of the initiation of the investigation.

6. No person who directs or exercises any authority in a residential facility, day program or specialized service shall evict, harass, dismiss or retaliate against a patient, resident or client or employee because he or any member of his family has made a report of any violation or suspected violation of laws, ordinances or regulations applying to the facility which he has reasonable cause to believe has been committed or has occurred.

7. Any person who is discharged as a result of an administrative substantiation of allegations contained in a report of **mistreatment**, abuse or neglect may, after exhausting administrative

remedies as provided in chapter 36, RSMo, appeal such decision to the circuit court of the county in which such person resides within ninety days of such final administrative decision. The court may accept an appeal up to twenty-four months after the party filing the appeal received notice of the department's determination, upon a showing that:

(1) Good cause exists for the untimely commencement of the request for the review;

(2) If the opportunity to appeal is not granted it will adversely affect the party's opportunity for employment; and

(3) There is no other adequate remedy at law.

630.167. This recommendation adds the word "mistreatment" to comport with Section 630.155. See the note related to Section 630.155.

630.168. If it is alleged or suspected that any patient, resident or client **who has been admitted on a voluntary or involuntary basis to a mental health facility or mental health program in which people are detained pursuant to Chapter 632, RSMo, or any patient, resident or client** in a residential facility**, [**or**]** day program **or specialized service** operated, funded or licensed by the department is being or has been subjected to patient or resident abuse which results in physical injury, and in cases of sexual abuse, the head of the facility **[**or**]**, program **or service** shall **[**,as specified in the department's rules and regulations,**]** **promptly** notify local law enforcement authorities and cooperate fully with any investigation by them.

630.168. See the note related to Section 630.110.1.

630.170.1 A person convicted of any crime under section 630.155, 630.160, or 630.165 shall be disqualified from holding any position in any **public or private** facility **or day program** operated **funded or licensed** by the department **or in any mental health facility or mental health program in which people are admitted on a voluntary or involuntary basis or are civilly detained pursuant to Chapter 632, RSMo.**

2. A person convicted of any felony offense against persons as defined in chapter 565, RSMo; of any felony sexual offense as defined in chapter 566, RSMo; of any felony offense defined in section 568.050, 568.060, 569.020, 569.030, 569.040, or 569.050, RSMo, or of an equivalent felony offense shall be disqualified from holding any direct-care position in any **public or private** facility, **day program, residential facility or specialized service** operated, **funded or licensed** by the

department **or any mental health facility or mental health program in which people are admitted on a voluntary basis or are civilly detained pursuant to Chapter 632, RSMo.**

630.170. See the note related to Section 630.110.1.

630.175.1. **No person admitted on a voluntary or involuntary basis to any mental health facility or mental health program in which people are civilly detained pursuant to Chapter 632, RSMo, and** no patient, resident or client of a residential facility or day program operated, funded or licensed by the department shall be subject to physical or chemical restraint, isolation or seclusion unless it is determined by the head of the facility or the attending licensed physician **that the chosen intervention is** [to be] **imminently** necessary to protect the **health and safety of the** patient, resident, client, or others**[,] and that it provides the least restrictive environment.**

2. Every use of physical or chemical restraint, isolation or seclusion and the reasons therefor shall be made a part of the clinical record of the patient, resident or client under the signature of the head of the facility or the attending licensed physician.
3. Physical or chemical restraint, isolation or seclusion shall not be considered standard treatment or habilitation and shall cease as soon as the circumstances causing the need for such action have ended.

630.175.1 These recommendations are made in light of *Bonds v. Missouri Department of Mental Health, supra*, and for the reasons stated in the note related to Section 630.110.1.

630.192. No biomedical or pharmacological research shall be conducted in **any mental health facility or mental health program in which people may be civilly detained pursuant to Chapter 632, RSMo, or in any public or private** residential facilities or day programs **or specialized services** operated, funded or licensed by the department for persons affected by mental retardation, developmental disabilities, mental illness, mental disorders or alcohol or drug abuse unless such research is intended to alleviate or prevent the disabling conditions or is reasonably expected to be of direct therapeutic benefit to the participants. **Without a specific court order**, no involuntary patient shall **consent to** participate in any **biomedical or pharmacological** research.

630.192. These recommendations are made for two reasons:
1) See the note related to Section 630.110.1; and
2) Involuntary patients should be allowed to participate in biomedical or pharmacological research that may be of benefit to them. Requiring court review will protect the patients from coerced participation.

630.199. Sections 630.194, 630.196 and 630.198 shall apply to all proposed biomedical or pharmacological research that involves persons civilly detained.

630.199. By referencing these sections, the Commission intends to provide the protections contained in the sections pertaining to all civilly detained persons, regardless of where that detention takes place.

630.200. In accordance with state and federal law, no mental health **facility or mental health program in which people may be civilly detained pursuant to Chapter 632, RSMo,** and no residential facility, day program or specialized service operated, funded or licensed by the department shall deny admission or other services to any person because of his race, sex, creed, marital status, national origin, [handicap]**, disability** or age.

630.200. See the note related to Section 630.110.1.

630.760. In addition to rights provided for patients, residents or clients of residential facilities licensed, **operated or funded** by the department under this chapter, **patients,** residents or clients in **mental health facilities or programs in which people may be civilly detained pursuant to Chapter 632, RSMo, or in** facilities and programs licensed, **operated or funded** by the department shall have the same rights as residents as defined in chapter 198, RSMo, have under section 198.088, RSMo.

630.760. See the note related to Section 630.110.1.

630.800. Nothing contained in this chapter shall be construed to transfer regulatory authority from the Department of Health to the Department of Mental Health.

630.800. Commission suggestions on extending client rights to persons in private facilities not necessarily operated, licensed or funded by the Department of Mental Health are not intended to cause the transfer of regulatory authority in general from the Department of Health to the Department of Mental Health. It is intended that the Department of Health will use its regulatory authority to enforce sections in Chapter 630, RSMo on the rights of persons in private facilities.

632.005. As used in chapter 631, RSMo, and this chapter, unless the context clearly requires otherwise, the following terms shall mean:

(1) "Comprehensive psychiatric services," any one, or any combination of two or more, of the following services to persons affected by mental disorders other than mental retardation or developmental disabilities: inpatient, outpatient, day program or other partial hospitalization, emergency, diagnostic, treatment, liaison, follow-up, consultation, education, rehabilitation, prevention, screening, transitional living, medical prevention and treatment for alcohol abuse, and medical prevention and treatment for drug abuse;

(2) "Council," the Missouri advisory council for comprehensive psychiatric services;

(3) "Court," the court which has jurisdiction over the respondent or patient;

(4) "Division," the division of comprehensive psychiatric services of the department of mental health;

(5) "Division director," director of the division of comprehensive psychiatric services of the department of mental health, or his designee;

(6) "Head of mental health facility," superintendent or other chief administrative officer of a mental health facility, or his designee;

(7) "Judicial day," any Monday, Tuesday, Wednesday, Thursday or Friday when the court is open for business, but excluding Saturdays, Sundays and legal holidays;

(8) "Licensed physician," a physician licensed pursuant to the provisions of chapter 334, RSMo, or a person authorized to practice medicine in this state pursuant to the provisions of section 334.150, RSMo;

(9) "Likelihood of serious [physical] harm" means any one or more of the following:

(a) A substantial risk that serious [physical] harm will be inflicted by a person upon his own person, as evidenced by recent threats, including verbal threats, or attempts to commit suicide or inflict physical harm on himself. **Evidence of substantial risk may include information about patterns of behavior that historically have resulted in serious harm previously being inflicted by a person upon himself; [or]**

(b) A substantial risk that serious [physical] harm to a person will result because of an impairment in his capacity to make decisions with respect to his hospitalization and need for treatment as evidenced by his inability to provide for his own basic necessities of food, clothing, shelter, safety or medical **or mental health** care[;]. **Evidence of that substantial risk may include information about patterns of behavior that historically have resulted in serious harm to the person previously taking place because he was unable to provide for his basic necessities of food, clothing, shelter, safety or medical or mental health care; or**

(c) A substantial risk that serious [physical] harm will be inflicted by a person upon another as evidenced by recent overt acts, behavior or threats, including verbal threats, which have caused such harm or which would place a reasonable person in reasonable fear of sustaining such harm. **Evidence of that substantial risk may include information about patterns of behavior that historically have resulted in serious harm previously being inflicted by a person upon another person.**

(10) "Mental health coordinator," a mental health professional who has knowledge of the laws relating to hospital admissions and civil commitment and who is appointed by the director of the department, or his designee, to serve a designated geographic area or mental health facility and who has the powers, duties and responsibilities provided in this chapter;

(11) "Mental health facility," any residential facility, public or private, which can provide evaluation, treatment and inpatient care to persons suffering from a mental disorder or mental illness and which is recognized as such by the department. No correctional institution or facility, jail, regional center or mental retardation facility shall be a mental health facility within the meaning of this chapter;

(12) "Mental health professional," a psychiatrist, resident in psychiatry, psychologist, psychiatric nurse or psychiatric social worker;

(13) "Mental health program," any public or private residential facility, public or private specialized service or public or private day program that can provide care, treatment, rehabilitation or services, either through its own staff or through contracted providers, in an inpatient or outpatient setting to persons with a mental disorder or mental illness or with a diagnosis of alcohol abuse or drug abuse and which is recognized as such by the department. No correctional institution or facility or jail may be a mental health program within the meaning of this chapter.

[(13)**]** **(14)** "Ninety-six hours" shall be construed and computed to exclude Saturdays, Sundays and legal holidays which are observed either by the court or by the mental health facility where the respondent is detained;

[(14)**]** **(15)** "Peace officer," a sheriff, deputy sheriff, county or municipal police officer or highway patrolman;

[(15)] **(16)** "Psychiatric nurse," a registered professional nurse who is licensed under chapter 335, RSMo, and who has had at least two years of experience as a registered professional nurse in providing psychiatric nursing treatment to individuals suffering from mental disorders;

[(16)] **(17)** "Psychiatric social worker," a person with a master's or further advanced degree from an accredited school of social work, **licensed under chapter 337 and** with a minimum of one year training or experience in providing psychiatric care, treatment or services in a psychiatric setting to individuals suffering from a mental disorder [or a degree from a graduate school deemed equivalent under rules and regulation adopted by the director];

[(17)] **(18)** "Psychiatrist," a licensed physician who in addition has successfully completed a training program in psychiatry approved by the American Medical Association, the American Osteopathic Association or other training program certified as equivalent by the department;

[(18)] **(19)** "Psychologist" a person [qualified] **licensed** to practice psychology under chapter 337, RSMo, with a minimum of one year training or experience in providing treatment or services to mentally disordered or mentally ill individuals;

[(19)] **(20)** "Resident in psychiatry," a licensed physician who is in a training program in psychiatry approved by the American Medical Association, the American Osteopathic Association or other training program certified as equivalent by the department;

[(20)] **(21)** "Respondent," an individual against whom involuntary civil detention proceedings are instituted pursuant to this chapter;

[(21)] **(22)** "Treatment," any effort to accomplish a significant change in the mental or emotional conditions or the behavior of the patient consistent with generally recognized principles or standards in the mental health professions.

632.005. (9) The Commission's recommendations on this topic are made for several reasons:

1) The Commission believes that its proposed changes must meet constitutional requirements within the standards of current case law; and

2) The Commission's proposals are intended to address five topics:

a) To change the current standard to establish that the types of incurred harm can be other than physical;

b) To correct the misperception that harm must be imminent;

c) To enunciate the principle of current case law, which states that likelihood of harm may take place without actual injury occurring. See Matter *of D.G.M.*, 838 S.W. 2d 501 (Mo. App. 1992) and *In the Matter of F.Z.*, 612 S.W.2d 904 (Mo. App. 1981);

(Continued on following page)

d) To add that historical patterns of behavior may be taken into account as evidentiary consideration of the likelihood of serious harm; and

e) To enunciate the principle of current case law, which states that failure to take medication, in and of itself, by a person with a mental illness or mental disorder who is to take that medication can constitute likelihood of serious harm. See *In the Matter of Todd*, 767 S.W. 2d 589 (Mo. App. 1988) and *In the Matter of Brown*, 746 S.W.2d 137 (Mo. App. 1988).

Note: In light of this recommendation, the Commission recommends deleting the word "physical" as it relates to "likelihood of serious harm" in the subsequent sections of Chapter 632, RSMo.

632.005.(13) The Commission recommends that the legal term of art "mental health program" be established in statute to expand the range of available least restrictive environments for placing clients.

632.005. (17) and (19) The Commission recommends addition of the term "licensed" to comply with recent changes in state statute.

632.055. The division shall provide or arrange for the provision of services in the least restrictive environment to mentally disordered and mentally ill persons based upon [their] **those persons'** diagnoses and individualized treatment plans on a continuum of services. **Core services to be provided to a patient, resident or client with a mental disorder or mental illness shall include —**

(1) Crisis intervention and stabilization services;
(2) Evaluation, assessment and diagnosis;
(3) Case management and monitoring; and
(4) Medication administration and management.

Notwithstanding any provision of law to the contrary, no person with a mental illness or a mental disorder shall be denied crisis intervention and stabilization services.

632.055. The Commission recommends that services listed in items (1) through (4) be the minimum core services available to all patients, residents or clients of the Department of Mental Health. After much deliberation, the Commission concurred that these four services are the foundation for effective care, treatment and rehabilitation of persons with a mental illness or mental disorder who are clients of the Department of Mental Health.

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The phrase beginning "Notwithstanding" is intended to ensure that all persons with a mental illness or disorder, regardless of whether they are current patients, residents or clients of the Department of Mental Health, shall receive necessary crisis intervention and stabilization services.

Also, see Chapter 3 of this report, which contains recommendations for improving the system for delivering mental health care services.

632.105.1. The head of a private mental health facility may, and the head of a department mental health facility shall, except in the case of a medical emergency and subject to the availability of suitable programs and accommodations, accept for evaluation, on an outpatient basis if practicable, any person eighteen years of age or over who applies for his admission **or whose advance directive authorizes applying for such admission or services.** The department may require that a community-based service where the person resides perform the evaluation pursuant to an affiliation agreement and contract with the department.

2. If a person is diagnosed as having a mental disorder, other than mental retardation or developmental disability without another accompanying mental disorder, and is determined to be in need of inpatient treatment, the person may be admitted by a private mental health facility and shall be admitted by a department mental health facility, if suitable accommodations are available, for care and treatment as an inpatient for such periods and under such conditions as authorized by law. The department may require that a community-based service where the patient resides admit the person for inpatient care and treatment pursuant to an affiliation agreement and contract with the department.
3. A person who is admitted under this section is a voluntary patient and shall have the right to consent to evaluation, care, treatment and rehabilitation and shall not be medicated without his prior voluntary and informed consent; except that medication may be given in emergency situations.

632.105.1 The Commission recommends that statutory language be added to recognize that an advance directive may be used to authorize a person's evaluation and treatment at a mental health facility.

632.120.1. The head of a private mental health facility may, and the head of a public mental health facility shall, except in the case of a medical emergency and subject to the availability of suitable programs and accommodations, accept for evaluation and treatment, on an outpatient basis if practicable, any person who has been declared incapacitated by a court of competent jurisdiction and for whom an

application for voluntary admission is made by his guardian **or any person as directed by that person's advance directive and for whom an application for voluntary admission is made pursuant to that person's advance directive.** The department may require that a community-based service where the person resides perform the evaluation pursuant to an affiliation agreement and contract with the department.

2. If the person is diagnosed as having a mental disorder, other than mental retardation or developmental disability without another accompanying mental disorder, and the person is found suitable for inpatient treatment as a result of the evaluation, the person may be admitted by a private mental health facility or shall be admitted by a public mental health facility, if suitable accommodations are available, for care, treatment and rehabilitation as an inpatient for up to thirty days after admission for evaluation and treatment.
3. If further inpatient services are recommended, the person may remain in the facility only if his guardian is authorized by the court to continue the inpatient hospitalization. The court may authorize the guardian to consent to evaluation, care, treatment, including medication, and rehabilitation on an inpatient basis.

632.120. The Commission recommends that the Revisor of Statutes amend the title to comport with prior changes in the guardianship code:

[Incompetents] **Incapacitated persons** to be accepted by heads of facilities upon application-duration of admission for evaluation-consent may be authorized.

632.120.1 The Commission recommends that statutory language be added to recognize that an advance directive may be used to authorize a person's evaluation and treatment at a mental health facility.

632.300. 1. When a mental health coordinator receives information alleging that a person, as the result of a mental disorder, presents a likelihood of serious [physical] harm to himself or others, he shall:

(1) Conduct an investigation;
(2) Evaluate the allegations and the data developed by investigation; and
(3) Evaluate the reliability and credibility of all sources of information.

2. If, as the result of personal observation or investigation, the mental health coordinator has reasonable cause to believe that such person is mentally disordered and, as a result, presents a likelihood of serious [physical] harm to himself or others, the mental health coordinator may file an application with the court having probate jurisdiction pursuant to the provisions of section 632.305; provided, however, that should the mental health coordinator have reasonable cause to believe, as the result of personal observation or investigation, that the likelihood of serious [physical] harm by such person to himself or others as a result of a mental disorder is imminent unless the person is immediately taken into custody, the mental health coordinator shall request

a peace officer to take or cause such person to be taken into custody and transported to a mental health facility in accordance with the provisions of subsection 3 of section 632.305.

3. If the mental health coordinator determines that involuntary commitment is not appropriate, he should inform either the person, his family or friends about those public and private agencies and courts which might be of assistance.

632.305. 1. An application for detention for evaluation and treatment may be executed by any adult person, who need not be an attorney or represented by an attorney, including the mental health coordinator, on a form provided by the court for such purpose, and must allege under oath that the applicant has reason to believe that the respondent is suffering from a mental disorder and presents a likelihood of serious [physical] harm to himself or to others. The application must specify the factual information on which such belief is based and should contain the names and addresses of all persons known to the applicant who have knowledge of such facts through personal observation.

2. The filing of a written application in court by any adult person, who need not be an attorney or represented by an attorney, including the mental health coordinator, shall authorize the applicant to bring the matter before the court on an ex parte basis to determine whether the respondent should be taken into custody and transported to a mental health facility. The application may be filed in the court having probate jurisdiction in any county where the respondent may be found. If the court finds that there is probable cause, either upon testimony under oath or upon a review of affidavits, to believe that the respondent may be suffering from a mental disorder and presents a likelihood of serious [physical] harm to himself or others, it shall direct a peace officer to take the respondent into custody and transport him to a mental health facility for detention for evaluation and treatment for a period not to exceed ninety-six hours unless further detention and treatment is authorized pursuant to this chapter. Nothing herein shall be construed to prohibit the court, in the exercise of its discretion, from giving the respondent an opportunity to be heard.

3. A mental health coordinator may request a peace officer to take or a peace officer may take a person into custody for detention for evaluation and treatment for a period not to exceed ninety-six hours only when such mental health coordinator or peace officer has reasonable cause to believe that such person is suffering from a mental disorder and that the likelihood of serious [physical] harm by such person to himself or others is imminent unless such person is immediately taken into custody. Upon arrival at the mental health facility, the peace officer or mental health coordinator who conveyed such person or caused him to be conveyed shall either present the application for detention for evaluation and treatment upon which the court has issued a finding of probable cause and the respondent was taken into custody or complete an application for initial detention for evaluation and treatment for a period not to exceed ninety-six hours which shall be based upon his own personal observations or investigations and shall contain the information required in subsection 1 of this section.

4. If a person presents himself or is presented by others to a mental health facility and a licensed physician, a registered professional nurse or a mental health professional designated by the head of the facility and approved by the department for such purpose has reasonable cause to believe

that the person is mentally disordered and presents an imminent likelihood of serious [physical] harm to himself or others unless he is accepted for detention, the licensed physician, the mental health professional or the registered professional nurse designated by the facility and approved by the department may complete an application for detention for evaluation and treatment for a period not to exceed ninety-six hours. The application shall be based on his own personal observations or investigation and shall contain the information required in subsection 1 of this section.

632.330. 1. At the expiration of the ninety-six hour period, the respondent may be detained and treated involuntarily for an additional two judicial days only if the head of the mental health facility or a mental health coordinator **either** has filed a petition for additional **inpatient** detention **and treatment** not to exceed twenty-one days **or has filed a petition for outpatient detention and treatment for a period not to exceed one hundred and eighty days.**

2. Within ninety-six hours following initial detention, the head of the facility or the mental health coordinator may file or cause to be filed **either** a petition for a twenty-one-day **inpatient** involuntary detention and treatment period **or a petition for outpatient detention and treatment for a period not to exceed one hundred eighty days**, provided he has reasonable cause to believe that the person is mentally ill and as a result presents a likelihood of serious [physical] harm to himself or others. The court shall serve the petition and list of prospective witnesses for the petitioner upon the respondent and his attorney at least twenty-four hours before the hearing. The head of the facility shall also notify the mental health coordinator if the petition is not filed by the mental health coordinator. The petition shall:

(1) Allege that the respondent, by reason of mental illness, presents a likelihood of serious [physical] harm to himself or to others;

(2) Allege that the respondent is in need of continued detention and treatment **either on an inpatient basis or on an outpatient basis**;

(3) Allege the specific behavior of the respondent or the facts which support such conclusion;

(4) Affirm that attempts were made to provide necessary care, treatment and services in the least restrictive environment to the respondent on a voluntary basis, but either the petitioner believes that the respondent lacks the capacity to voluntarily consent to care, treatment and services or the respondent refuses to voluntarily consent to care, treatment and services such that proceeding with a petition for the respondent's civil detention in the least restrictive environment is necessary;

(5) Allege that there will be appropriate support from family, friends, case managers or others during the period of outpatient detention and treatment in the community if such commitment is sought;

[(4)] **(6)** [Allege that a] **Specify the** mental health **program** [facility] **that** [which] is appropriate to handle the respondent's condition **and that** has agreed to accept the respondent; [and]

(7) Specify the range of care, treatment, and services that shall be provided to the respondent if the petition for further detention is sustained by the court;

(8) **Name the entities to fund and provide the specified interventions; and**

[(5)] (9) Be verified by a psychiatrist or by a licensed physician and a mental health professional who have examined the respondent.

3. **Before proceeding with a petition for civil detention as set out in section 632.330.2, the petitioner shall consider whether based on the respondent's condition and treatment history, the respondent meets the criteria in chapter 475, RSMo, so that appointment of a full or limited guardian or conservator is appropriate for the court to consider, and if deemed so, the petitioner then shall proceed as specified in section 632.330.4.**

4. **If the head of the mental health facility, or his designee, or the mental health coordinator believes that the respondent, because of a mental illness or mental disorder, may be incapacitated or disabled as defined in chapter 475, RSMo, the head of the mental health facility or mental health coordinator shall cause a petition to be filed pursuant to section 475.060, and section 475.061 if applicable, with the court having probate jurisdiction as determined by section 475.035. In addition, if the head of the mental health facility, his designee or the mental health coordinator believes it appropriate, he shall proceed with obtaining an order for the respondent's temporary emergency detention as provided for in section 475.355. Furthermore, the hearing on the petition filed pursuant to chapter 475, RSMo, shall be conducted pursuant to the requirements of section 475.075 and other appropriate sections of chapter 475, RSMo, and shall be held within two judicial days after termination of the 96-hour civil detention period unless continued for good cause shown. Nothing contained in this subsection shall restrict or prohibit the head of the mental health facility, his designee or the mental health coordinator from proceeding under the appropriate provisions of chapter 632, RSMo, if the petition for guardianship or conservatorship is denied.**

632.330. Recommended changes to this section are intended to do two things:
1) Establish the legal framework for outpatient detention and treatment; and
2) Direct consideration of the appropriateness of pursuing legal guardianship as a tool for obtaining care and treatment for a person with mental illness.

The Commission recommends establishing a framework for using outpatient detention and treatment as an option to enhance availability of legal mechanisms for accessing services. The outpatient framework should be established via a pilot program, including both a rural and urban region, to access treatment and assess cost effectiveness prior to its implementation statewide.

(Continued on following page)

For certain individuals, outpatient detention and treatment may provide --
1) A less restrictive environment;
2) A less intrusive treatment intervention;
3) Greater therapeutic effectiveness; and
4) More cost effective treatment.

For the mental health care services delivery system, using outpatient detention and treatment --
1) Encourages creativity in the delivery of outpatient services;
2) Directs and enhances responsibility by the outpatient services provider; and
3) Promotes accountability to the consumer and from the funding source.

Note: The previous discussion regarding the framework for using outpatient detention and treatment also applies to proposed changes to Sections 632.335, 632.337, 632.340, 632.350 and 632.355.

The Commission's recommendation that the time period for outpatient detention and treatment may be up to 180 days is based on three considerations:
1) Clinical opinion from members of the Commission suggests that up to 180 days in a non-inpatient setting is the time required to adequately allow for recovery and stabilization and to establish compliance with medication and the treatment plan;
2) The proposed time period is compatible with other requirements in Chapter 632, RSMo; and
3) A review of the literature reveals that in those states that use outpatient detention and treatment, there is no uniformity in the duration of the detention.

The Commission also recommends in Section 632.330.3 that petitioners should consider the appropriateness of pursuing guardianship for persons for whom they are considering pursuit of civil commitment. Testimony before the Commission raised its awareness that using guardianship for some persons with mental illness or a mental disorder may provide more efficient and timely access to services. Also, see Section 632.330.4 and that portion of this report that recommends further study of enhancements to the guardianship and public administration systems.

632.335. 1. The petition for [twenty-one-day involuntary detention and treatment] **additional inpatient detention and treatment not to exceed twenty-one days or the petition for outpatient detention and treatment not to exceed one hundred and eighty days** shall be filed with the court having probate jurisdiction. At the time of filing the petition, the court clerk shall set a date and time for the hearing which shall take place within two judicial days of the filing of the petition. The clerk shall promptly notify the respondent, his attorney, the petitioner and the petitioner's attorney of the date and time for the hearing. The court shall not grant continuances except upon a showing of

good and sufficient cause. If a continuance is granted, the court, in its discretion, may order the person released pending the hearing upon conditions prescribed by the court. The court may order the continued detention and treatment of the person at a mental health facility pending the continued hearing, and a copy of such order shall be furnished to the facility.

2. The hearing shall be conducted in as informal a manner as may be consistent with orderly procedure and in a physical setting not likely to have a harmful effect on the respondent. Due consideration shall be given by the court to holding a hearing at the mental health facility. The respondent shall have the following rights in addition to those specified elsewhere:

(1) To be represented by an attorney;
(2) To present evidence on his own behalf;
(3) To cross-examine witnesses who testify against him;
(4) To remain silent;
(5) To view and copy all petitions and reports in the court file of his case;
(6) To have the hearing open or closed to the public as he elects;
(7) To be proceeded against according to the rules of evidence applicable to civil judicial proceedings;
(8) To request a hearing before a jury.

3. The respondent shall be present at the hearing, unless the respondent's physical condition is such that he cannot be present in the courtroom or if the court determines that the respondent's conduct in the courtroom is so disruptive that the proceedings cannot reasonably continue.

4. At the conclusion of the hearing, if the court finds, based upon clear and convincing evidence, that **the** respondent, as the result of mental illness, presents a likelihood of serious [physical] harm to himself or to others, and that a **mental health program** appropriate to handle the respondent's condition has agreed to accept him, the court shall order **either** that the respondent be detained for **inpatient** involuntary treatment in the least restrictive environment for a period not to exceed twenty-one days **or be detained for outpatient detention and treatment under the supervision of a mental health program in the least restrictive environment for a period not to exceed one hundred and eighty days**.

632.337. 1. When the court has ordered up to one hundred eighty days of outpatient detention and treatment pursuant to sections 632.335 or 632.350 or 632.355, and the supervisory mental health program has good cause to believe that immediate detention in a more appropriate least restrictive environment is required because the respondent presents a likelihood of serious harm due to mental illness, the supervisory mental health program may direct that the respondent be detained for up to ninety-six hours at an appropriate mental health program that has agreed to accept the respondent and may authorize the sheriff to detain and transport the respondent to that mental health program. Detention for more than ninety-six hours shall be pursuant to section 632.330.

2. **Evidence of detention for ninety-six-hour periods during the one hundred eighty-day outpatient commitment may be considered by the court in determining additional periods of detention and treatment.**

632.337. The Commission recommends this language to provide an appropriate due process mechanism by which a person detained for a period of outpatient detention and treatment may be re-evaluated to determine whether inpatient detention and treatment are necessary. The proposal also would authorize law enforcement personnel to detain and transport the individual to a mental health program.

632.340. 1. Before the expiration of the twenty-one-day **inpatient** detention and treatment period ordered pursuant to section 632.335, the court may order the respondent to be detained and treated involuntarily for an additional period not to exceed ninety **inpatient** days[;] **or may order the respondent to be detained for outpatient treatment for a period not to exceed one hundred and eighty days**; provided, that:

(1) The respondent is mentally ill and continues to present a likelihood of serious [physical] harm to himself or others; and

(2) The court, after a hearing, orders the respondent detained and treated for the additional period.

2. If, within seventeen days of the court hearing described in section 632.335, the head of the mental health [facility] **program** or the mental health coordinator has reasonable cause to believe that the respondent is mentally ill and as a result presents a likelihood of serious [physical] harm to himself or others, and believes that further detention and treatment is necessary, he shall file, or cause to be filed, with the court a petition for ninety days additional detention and treatment **or a petition for outpatient detention and treatment for a period not to exceed one hundred and eighty days**. The court shall immediately set a date and time for a hearing on the petition, which shall take place within four judicial days of the date of the filing of the petition. The court shall serve a copy of the petition and the notice of the date and time of the hearing upon the petitioner, the respondent, and their attorneys as promptly as possible, but not later than two judicial days after the filing of the petition. The petitioner shall also file with the court, for the court to serve upon the respondent's attorney not later than two judicial days after the filing of the petition, a list of the proposed witnesses for the petitioner. The head of the mental health [facility] **program** shall notify the mental health coordinator if the petition is not filed by the mental health coordinator. The petition shall comply with the requirements of section 632.330, and an individualized treatment plan for the respondent shall be attached thereto.

632.340. See the note related to outpatient detention and treatment in Section 632.330.

632.345. 1. If requested by the respondent, the court shall appoint an available licensed physician to examine him and testify at the respondent's request. If the respondent or his counsel so request, the court shall not appoint a physician who is on the staff of the [facility] **program** wherein the person is detained, and if the respondent is detained in a [facility] **program** operated by the department and respondent or his counsel so request, the court shall not appoint a physician who is an employee of the department.

2. The court may grant continuances but shall do so only upon a showing of good and sufficient cause.

3. The respondent shall continue to be detained and treated pending the hearing unless released by order of the court. If a continuance is granted, the court, in its discretion, may order respondent released upon conditions described by the court pending the hearing. If no order has been made within thirty days after the filing of the petition, not including extensions of time requested by the respondent and granted, the respondent shall be released.

632.345. See the note related to Section 632.005. (13).

632.350. 1. The hearing for a ninety-day **inpatient** detention and treatment period **or for outpatient detention and treatment for a period not to exceed one hundred and eighty days** shall be conducted in as informal a manner as may be consistent with orderly procedure and in a physical setting not likely to have a harmful effect on the mental health of the respondent. If a jury trial is not requested, due consideration shall be given by the court to holding a hearing at the mental health [facility] **program**. The hearing shall be held in accordance with the provisions set forth in section 632.335.

2. The burden of proof at the hearing shall be by clear and convincing evidence and shall be upon the petitioner.

3. If the matter is tried before a jury, the jury shall determine and shall be instructed only upon the issues of whether or not the respondent is mentally ill and, as a result, presents a likelihood of serious [physical] harm to himself or others. The remaining procedures for the jury trial shall be as in other civil matters.

4. The respondent shall not be required to file an answer or other responsive pleading.

5. At the conclusion of the hearing, if the court or jury finds that the respondent, as the result of mental illness, presents a likelihood of serious [physical] harm to himself or to others, and the

court finds that a [facility] **program** appropriate to handle the respondent's condition has agreed to accept him, the court shall order the respondent to be detained for involuntary treatment in the least restrictive environment for a period not to exceed ninety days **or for outpatient detention and treatment under the supervision of a mental health program in the least restrictive environment for a period not to exceed one hundred and eighty days.**

632.350. See the note related to Section 632.330.

632.355. 1. At the expiration of the ninety-day **inpatient** commitment period ordered by the court pursuant to section 632.350, the respondent may be detained and treated **as an** involuntarily **inpatient** for an additional period of time not to exceed one year or such lesser period of time as determined by the court[;] **or may be detained for outpatient treatment for a period of time not to exceed one hundred and eighty days**; provided, that:

(1) The respondent is mentally ill and continues to present a likelihood of serious [physical] harm to himself or to others; and

(2) The court after a hearing orders the person detained and treated for the additional period.

2. Within the ninety-day commitment period, the head of the mental health [facility] **program** or the mental health coordinator may file or cause to be filed [a petition]**, in compliance with the requirements of section 632.330, a petition** for a one-year **inpatient** detention and treatment period **or a petition for outpatient detention and treatment for a period not to exceed one hundred days** if he has reasonable cause to believe that the respondent is mentally ill and as a result presents a likelihood of serious [physical] harm to himself or others, and that further detention and treatment is necessary pursuant to an individualized treatment plan prepared by the [facility] **program** and filed with the court. Procedures specified in sections 632.340, 632.345 and 632.350 shall be followed.

3. At the conclusion of the hearing, if the court or jury finds that the respondent, as the result of mental illness, presents a likelihood of serious [physical] harm to himself or others, and the court finds that a [facility] **program** appropriate to handle the respondent's condition has agreed to accept him, the court shall order that the respondent be detained for involuntary treatment in the least restrictive environment for a period not to exceed one year **or for outpatient detention and treatment under the supervision of a mental health program in the least restrictive environment for a period not to exceed one hundred and eighty days.**

632.355. See the note related to Section 632.330.

632.365 Notwithstanding any other provision of the law to the contrary, whenever a court orders a person detained for involuntary treatment in a mental health [facility] **program** operated by the department, the order of detention shall be to the custody of the director of the department, who shall determine where detention and involuntary treatment shall take place in the least restrictive environment**, be it an inpatient or outpatient setting.**

632.365. See the notes related to Sections 632.005. (13) and 632.330.

632.370. 1. The department may transfer, or authorize the transfer of, an involuntary patient detained under this chapter, chapter 211, RSMo, chapter 475, RSMo, or chapter 552, RSMo, from one mental health [facility] **program** to another if the department determines that it would be consistent with the medical needs of the patient to do so. If a minor is transferred from a ward for minors to an adult ward, the department shall conduct a due process hearing within six days of such transfer during which hearing the head of the [facility] **program** shall have the burden to show that the transfer is appropriate for the medical needs of the minor. Whenever a patient is transferred, written notice thereof shall be given after obtaining the consent of the patient, his parent if he is a minor or his legal guardian to his legal guardian, parents and spouse, or, if none be known, his nearest known relative or friend. In all such transfers, due consideration shall be given to the relationship of the patient to his family, legal guardian or friends, so as to maintain relationships and encourage visits beneficial to the patient. The head of the mental health [facility] **program** shall notify the court ordering detention or commitment, the patient's last known attorney of record and the mental health coordinator for the region of such transfer. In the case of a patient committed under chapter 211, RSMo, the court, on its own motion, may hold a hearing on the transfer to determine whether such transfer is appropriate to the medical needs of the patient.

2. Upon receipt of a certificate of an agency of the United States that facilities are available for the care or treatment of any individual heretofore ordered involuntarily detained, treated and evaluated pursuant to this chapter in any facility for the care or treatment of the mentally ill, mentally retarded or developmentally disabled and that such individual is eligible for care or treatment in a hospital or institution of such agency, the department may cause his transfer to such agency of the United States for hospitalization. Upon effecting any such transfer, the court ordering hospitalization, the legal guardian, spouse and parents, or, if none be known, his

nearest known relative or friend shall be notified thereof immediately by the department. No person shall be transferred to an agency of the United States if he is confined pursuant to a conviction for any felony or misdemeanor or if he has been acquitted of any felony or misdemeanor solely on the ground of mental illness, unless prior to transfer the court originally ordering confinement of such person enters an order for the transfer after appropriate motion and hearing. Any person transferred to an agency of the United States shall be deemed to be hospitalized by such agency pursuant to the original order of hospitalization.

632.370. See the note related to Section 632.005. (13).

632.375. 1. At least once every one hundred eighty days, the head of each mental health [facility] **program** shall have each respondent who is detained at the [facility] **program** for a one-year period under this chapter examined and evaluated to determine if the respondent continues to be mentally ill, and as a result presents a likelihood of serious [physical] harm to himself or others. The court, the mental health coordinator for the region, the respondent and the respondent's attorney shall be provided copies of the report of the examination and evaluation described by this section and the respondent's individualized treatment plan.

2. Upon receipt of the report, the court may, upon its own motion, or shall, upon the motion of the respondent, order a hearing to be held as to the need for continued detention and involuntary treatment. At the conclusion of the hearing, the court may order:

(1) The discharge of the respondent; or

(2) An appropriate least restrictive course of detention and involuntary treatment; or

(3) The respondent to be remanded to the mental health [facility] **program** for the unexpired portion of the original commitment order.

632.375. See the note related to Section 632.005. (13).

632.380. Persons who are mentally retarded, developmentally disabled, senile or impaired by alcoholism or drug abuse shall not be detained judicially under this chapter, unless they are also mentally ill and as a result present likelihood of serious [physical] harm to themselves or to others. Such persons may, however, be committed upon court order under this chapter and the provisions of chapter 475 RSMo, relating to incapacitated persons, pursuant to chapter 211, RSMo, relating to juveniles, or may be admitted as voluntary patients under section 632.105 or 632.120.

632.390. 1. The head of a mental health [facility] **program** shall release any person who is involuntarily detained under this chapter when, in his opinion, the person is no longer mentally ill or, although mentally ill, does not present a likelihood of serious [physical] harm to himself or others, even though the detention period has not expired.

2. Whenever the head of a mental health [facility] **program** discharges a person prior to the expiration of the detention order, he shall notify in writing the court and the mental health coordinator.

3. Whenever a respondent voluntarily admits himself and the head of a mental health [facility] **program** accepts the admission application submitted by respondent in good faith under section 632.105, the respondent's involuntary detention shall cease, and the head of the [facility] **program** shall notify in writing, the court and the mental health coordinator.

632.390. See the note related to Section 632.005. (13).

632.392. 1. Notwithstanding the provisions of section 630.140.1, RSMo, a mental health program and any treating physician, upon release of a patient who was committed or who is civilly detained and consents to voluntary treatment during the course of the inpatient stay pursuant to sections 632.150, 632.155, 632.300, 632.305, 632.330, 632.335, 632.340, 632.350, 632.355 or 632.375:

(1) Shall provide to the patient and his care provider a written packet of educational information developed and supplied by the department of mental health and describing symptoms of common mental illnesses, early warning signs of decompensation, and availability of other education, community and statewide services. The packet shall also include the telephone number of the department of mental health information line and information specific to the laws and procedures addressing civil detention and guardianship;

(2) May disclose confidential treatment information to the primary care provider or care providers, when such information is medically necessary for the provision of appropriate health care or treatment by the care provider or is related to the safety of the patient or care provider.

2. Prior to disclosure of the information specified under subdivision (2) of subsection 1 of this section, the mental health facility shall provide written notice to the patient; request in writing the consent of the patient; work with the patient and care provider to encourage and secure appropriate patient authorization; function as a mediator, negotiating the boundaries of confidentiality to meet the needs of the client and care provider; and work with the client to stress the importance of keeping the care provider informed and involved with his treatment process. If the patient refuses to

consent and the treating physician deems the information is medically necessary for the appropriate provision of health care or treatment by the care provider or is related to the safety of the patient or care provider, the information may still be released to the appropriate care provider. The reason for the intended disclosure, the specific information to be released and the persons to whom the disclosure is to be made, even if consent has not been obtained, will be provided to the client and care provider. All these procedures shall be documented by the treating physician in the client record, including a specific notation as to whether client consent was given.

3. As used in this section, the term "care provider" means the person or persons who can demonstrate that they are primarily responsible for the health care of the person with a mental illness. The term does not apply to any person providing care through hospitals, nursing homes, group homes or any other such facility.

632.392. These Commission recommendations have been made for the following reasons:

1) Regarding Section 632.392.1(1), testimony before the Commission established a common theme among families that in the early stages of dealing with their family members who have mental illness, the families --
   a) Are unaware of the enormity of their family members' needs;
   b) Often have inadequate information on mental illness and its ramifications for consumer and family dysfunction; and
   c) Do not know where to find services;
2) Regarding Sections 632.392.2. and .3., this proposal is meant to assure that, notwithstanding Section 630.140 to the contrary, "care providers" with primary responsibility for the persons' care shall have access to information deemed medically necessary for the appropriate care and treatment of the persons or information that is related to the safety of the persons or "care providers." The proposal presents safeguards on how this information shall be distributed; and
3) The Commission recommends that the Department of Mental Health promulgate an administrative rule directing the physician, in making a determination under Subsection 2, to ascertain whether or not the patient possessed capacity to consent to hospitalization at the time of admission and, if so, disclosure shall not be made.

632.393. **The department of mental health shall establish and maintain a telephone information line twenty-four hours a day, seven days a week to assist with crisis situations and provide crisis information, including referral of callers to community mental health resources and programs in the callers' areas.**

632.393. This recommendation is made to assure that families and consumers have available statewide a 24-hour-a-day, seven-day-a-week source of reliable information and referral services.

632.400. Any respondent ordered detained for ninety-day or one-year periods of involuntary **inpatient** treatment **or ordered detained for a period of up to one hundred eighty days of outpatient treatment** under this chapter shall be entitled to a reexamination of the order for his detention on his own motion, or that of his legal guardian, parent, spouse, relative, friend or attorney to the court. Upon receipt of the motion, the court shall conduct or cause to be conducted by a special commissioner proceedings in accordance with section 632.340.

632.400. See the note related to Section 632.330.

632.410. Venue for proceedings for involuntary detentions pursuant to the provisions of this chapter shall be in the court having probate jurisdiction in the county in which the mental health [facility] **program** is located wherein the respondent is detained; provided, however, that if the respondent is a resident of this state and makes application for the hearing to be held in his county of residence, the court shall order the proceedings, with all papers, files and transcripts of the proceedings, to be transferred to the court having probate jurisdiction in the respondent's county of residence. Once a court has assumed jurisdiction with respect to involuntary detention proceedings, no other court shall assume jurisdiction until the court having prior jurisdiction has transferred jurisdiction and all papers, files, and transcripts. If the court having jurisdiction receives notice that a respondent has been transferred to a mental health [facility] **program** in another county, the court shall transfer jurisdiction, along with all papers, files and transcripts, to the court in the county where the respondent has been transferred.

632.410. See the note related to Section 632.005. (13).

632.415. 1. The judge having probate jurisdiction in each county where a mental health [facility] **program** is located shall prepare and maintain a current register of attorneys who have agreed to be appointed to represent respondents against whom involuntary civil detention proceedings have been instituted in such county. The judge may choose lawyers who are paid by an public or private agency or other lawyers who are appointed to the register. The register shall be provided to the mental health coordinator for the area which includes the county for which the list was prepared. A new register shall be provided to the mental health coordinator each time a new attorney is added.

2. If the judge finds that the respondent is unable to pay [an] attorney's fees for the services rendered in the proceedings, the judge shall allow a reasonable attorney's fee for the services, which fee shall be assessed as costs and with rules and regulations promulgated by the state court administrator, from funds appropriated to the office of administration for such purposes provided that no attorney's fees shall be allowed for services rendered by an attorney who is a salaried employee of a public agency or a private agency which receives public funds.

632.415. See the note related to Section 632.005. (13).

632.440. No officer of a public or private agency, mental health facility[,] **or mental health program;** [nor the] **no** head, attending staff or consultant[s] of any such agency, [or] facility **or program;** [nor any] **no** mental health coordinator, registered professional nurse, licensed physician, mental health professional [or] **nor** any other public official performing functions necessary for the administration of this chapter; **no guardian acting pursuant to sections 475.120 and 475.121;** [nor any] **no** peace officer responsible for detaining a person pursuant to this chapter; **and** [nor any] **no** peace officer responsible for detaining or transporting, or both, any person upon the request of any mental health coordinator pursuant to sections 632.300 or 632.305, regardless of whether such peace officer is outside the jurisdiction for which he serves as a peace officer during the course of such detention or transportation, or both, shall be civilly liable for detaining, transporting, conditionally releasing or discharging a person pursuant to this chapter **or chapter 475, RSMo,** at or before the end of the period for which [he] **the person** was admitted or detained for evaluation or treatment[,] so long as such duties were performed in good faith and without gross negligence.

632.440. See the note related to Section 632.005. (13). In addition, the Commission recommends that Section 632.440 be amended to provide limited protection for guardians acting pursuant to Sections 475.120 and 475.121 and for those agents acting pursuant to the guardians' direction.

632.455.1. If requested to do so by the head of a mental health [facility] **program**, the sheriff of the county where a patient absent without authorization is found shall apprehend and return him to the [facility] **program**.

2. The head of the [facility] **program** may request the return of an absent patient under subsection 1 of this section only under one or more of the following circumstances:

(1) The patient is a minor whose admission was applied for by his parent or legal custodian, who has not requested the minor patient's release;

(2) The patient is a minor under jurisdiction of the juvenile court;

(3) The patient has been declared legally [incompetent] **incapacitated** and his guardian has not requested his release;

(4) The patient was committed to the department under chapter 552, RSMo or this chapter;

(5) The patient's condition is of such a nature that, for the protection of the patient or others, the head of the [facility] **program** determines that the patient's return to the [facility] **program** is necessary as noted in the patient's records, in which case civil detention procedures shall be initiated upon return to the [facility] **program**.

632.455. See the note related to Section 632.005. (13).

475.124. No officer of a public or private agency, mental health facility or mental health program; no head, attending staff or consultant of any such agency, facility or program; no mental health coordinator, registered professional nurse, licensed physician, mental health professional nor any other public official performing functions necessary for the administration of this chapter; no guardian acting pursuant to sections 475.120 or 475.121; no peace officer responsible for detaining a person pursuant to this chapter; and no peace officer responsible for detaining or transporting, or both, any person upon the request of any mental health coordinator pursuant to sections 632.300 and 632.305, regardless of whether such peace officer is outside the jurisdiction for which he serves as a peace officer during the course of such detention or transportation, or both, shall be civilly liable for detaining, transporting, conditionally releasing or discharging a person pursuant to this chapter or chapter 632, RSMo, at or before the end of the period for which the person was admitted or detained for evaluation or treatment so long as such duties were performed in good faith and without gross negligence.

475.124. The Commission recommends adopting this proposal to assure limited protection for guardians acting pursuant to Sections 475.120 and 475.121, for mental health professionals and mental health coordinators acting in the administration of Chapter 632, RSMo, and for agents acting pursuant to guardians', mental health professionals' or mental health coordinators' direction.

This proposal helps meet the concern expressed to the Commission that guardians have difficulty accessing law enforcement assistance due to statutory vagueness about the authority of guardians to request such assistance and the reluctance of peace officers to assist guardians without assurance of the guardians' authority.

CHAPTER

2

Policy Statement on Education

Both at the public hearings and during McBride Commission discussions, the theme consistently voiced was that people often have no information, conflicting information or misinformation about the mental health care services delivery system and laws pertaining to people with mental illness. Furthermore, the Commission finds that the civil commitment laws are not uniformly applied throughout the state. These issues prompted a unanimous belief by the Commission that education is a priority.

The Commission recognizes that the need for education may vary within the population to be addressed. However, the following observations and proposals are offered to address the overall need for education.

The Commission sets the following education goals:

Increased knowledge among primary and secondary consumers of the signs and symptoms of mental illness and decompensation;

Easier entry into the mental health care services delivery systems in times of need to prevent crises;

Improved continuity of inpatient and outpatient care within the public and private mental health care services delivery systems;

Enhanced collaboration between the public and private mental health care services delivery systems;

Increased public knowledge about laws pertaining to people with mental illness to better enable those people to get the care they need when they need it;

Increased knowledge of laws pertaining to responsibilities and liability so that professionals will not be reluctant to help people with mental illness to prevent crises;

Standardized interpretation of civil commitment laws to ensure effective intervention while maintaining due process safeguards; and

Increased knowledge about medications and interventions to treat mental illness.

Indeed, the Commission believes the need for education is critical and widespread, as evidenced by the following groups it has targeted for increased understanding of mental illness and of the civil commitment and guardianship processes:

People with mental illness;

Families, friends, guardians and caretakers;

Public administrators;

Judges, lawyers, prosecutors and county counselors;

Peace officers;

Mental health professionals;

Public and private mental health communities;

Primary care physicians; and the

Public at large.

The Commission recommends that the education and training curriculum contain at least the following content areas:

Signs and symptoms of mental illness and decompensation;

Ways to access the mental health care services delivery systems in times of need and to prevent crises;

The array of services within public and private mental health care services delivery systems;

Laws pertaining to people with mental illness; and

Laws pertaining to persons caring for, and professionals working with, people with mental illness.

Increased knowledge about medications and interventions to treat mental illness.

The Commission recommends at least the following vehicles as a means of providing public education:

Continuing legal and medical education;

Public forums;

Inservice training for peace officers;

Comprehensive multidisciplinary training and a reference manual dealing with mental health, substance abuse and developmental disabilities (laws, procedures and practical issues); and

Pamphlets and other materials.

Every profession involved with the civil commitment process must contribute to ongoing education of its constituents. The Commission also recommends a coordinated approach toward accomplishment of the education goals it has established. It further recommends that leadership in this coordination be taken by The Missouri Bar in conjunction with the Department of Mental Health.

CHAPTER

3

Policy Statement on Services and Supports

The McBride Commission believes that Governor Carnahan, the General Assembly, the Department of Mental Health and other state agencies serving persons with mental illness should commit themselves to developing an improved system of mental health care. The Commission recommends shifting the focus from the current system of crises reaction to a system that focuses on crisis prevention and early intervention in the community in which the person lives.

It is very apparent that the services system operated by the Department of Mental Health and its contractors lacks the fiscal and program resources to successfully implement the system recommended by the Commission. Therefore, the Commission further recommends that the Governor, the General Assembly and the Department of Mental Health commit themselves to securing necessary additional resources. Additional funding must not be provided by diverting funds from existing mental health programs and services.

In making its recommendations for improved mental health services in Missouri, the Commission is guided by the following principles:

To help ensure that involuntary commitment is a seldom used last resort, four core services must serve as the foundation for effective care, treatment and rehabilitation —

- Crisis intervention and stabilization;
- Evaluation, assessment and diagnosis;
- Case management and monitoring; and
- Medication administration and management.

A wide range of early intervention services, constituting a continuum of care, must be available to assist families and caregivers in providing timely supports and services to prevent crises;

The services system must have a primary consumer focus directed toward stabilization, well-being and growth and must include the assistance of peer consumers in the delivery of treatment services;

Primary consumers must be given opportunities to participate in ongoing development and evaluation of a full range of quality services and interventions that together constitute a continuum of care;

Programs and services must respect the dignity of persons with mental illness, their families and their caregivers; and

All services and supports must be culturally specific, culturally diverse and culturally competent and effective.

The Commission submits the following ideas and guidelines for implementing the system of services embodied in its report and for reducing the need for involuntary commitment. (See Finding and Recommendation 1 in the Commission's Executive Summary for its recommendations on involuntary outpatient commitment. See Findings and Recommendations 1 and 2 for recommendations on inpatient commitment.) These ideas and guidelines are the result of public testimony, review of current mental health statutes and literature and numerous meetings of discussion and deliberation by the Commission. Therefore, the Commission urges that these recommendations be considered for incorporation into the Department of Mental Health's philosophy and programs, be supported by the executive and legislative branches and be backed by financial resources and statutory authority.

The Commission endorses the Access and Crisis Service System now being implemented by the Department of Mental Health and urges its funding as a core service available to all persons who need it, even if they are not current recipients of Department services. See Findings and Recommendations 3 and 8 in the Commission's Executive Summary;

A statewide source of reliable information and referral should be available 24 hours a day, seven days a week to all Missourians, including those persons not receiving services from the Department of Mental Health. See Findings and Recommendations 6 and 8 in the Commission's Executive Summary;

The four core services previously identified in this policy statement should be available to all clients of the Department of Mental Health's Division of Comprehensive Psychiatric Services. See Finding and Recommendation 3 in the Commission's Executive Summary;

The Department of Mental Health should develop, expand or take advantage of the following interventions within its services delivery system:

Prevention and early intervention services, including respite care and in-home consultation and counseling for adults. (The Families First Program provides an example of a successful model.);

Psychiatric consultation and medication services;

Day treatment and psycho-social rehabilitation with emphasis on peer consumer participation in delivering these services;

Vocational rehabilitation, supported employment and other vocational services;

Medication coupled with psychotherapy;

Hotlines, consumer-operated businesses, drop-in centers and other self-help and mutual assistance programs with increased opportunities for consumer participation in those programs; and

Safe and adequate housing with supports necessary to maintain that housing. (Jobs and decent homes are critical factors in providing stability for consumers. Living in shelters or on the streets only guarantees continued instability and crises.);

The Commission further recommends that the Department of Mental Health investigate using mediation as a component of the mental health services system, and include input from experts in the field, consumers, family members and service providers as a part of that study. Mediation may offer consumers reluctant to use mental health services a forum for their concerns to be fairly addressed and may increase the effective use of treatment services. Implementation may include training to ensure competent use of mediation.

The Department of Mental Health should enhance its management information and quality improvement systems to better monitor delivery of services, quality of care and treatment, clinical outcomes, consumer satisfaction and consumer dissatisfaction. The system also should provide an information base for improving the mental health services delivery systems.

Finally, the Commission makes the following observations and recommendations:

It is not clear whether Missouri statutes provide for advance directives for mental health care. The Commission recommends study of this issue, the outcome of which would be availability of psychiatric advance directive options for persons with mental illness;

The Commission sees the need for improved communication among representatives of the legal system, representatives of the service delivery system and consumers. It recommends that the probate judges take the lead in establishing needed communication at county or multi-county levels; and

The Commission recommends that adequate resources be made available to peace officers whose skilled intervention is often needed to address the problems of persons with mental illness. Specifically, the Commission recommends —

More mental health coordinators and crisis intervention specialists to assist peace officers;

Development and implementation of comprehensive mental health training programs for peace officers; and

Reimbursement for peace officers who transport persons with mental illness to or from mental health facilities.

A more effective mental health delivery system as delineated within this services and supports report will, if implemented to its logical conclusion, lead to civil commitment becoming an option of last resort.

CHAPTER

4

Policy Statement on the Public Administrator Process

The McBride Commission believes that the mental health system has not effectively addressed many of the problems surrounding treatment. Too often, treatment is not obtained until clients have decompensated to the point at which inpatient hospitalization is necessary. Under the present "dangerousness" standard, inpatient time is usually too short to ensure that clients will not relapse. Another very real problem is maintaining clients on medication after their discharge. Many involuntary admissions result from the inability to maintain clients on medications while those clients live in the community.

The Department of Mental Health is responding to these problems by introducing its Access/Crisis Intervention System. The new system is to --

Provide immediate response, intervention and referral on a 24-hour basis for persons experiencing mental health crises;
Provide community-based crisis intervention in the least restrictive environment;
Prevent hospitalization if possible;
Stabilize clients in crisis and refer them to appropriate services; and
Link former clients with ongoing services, resources and supports, including natural supports.

There is general consensus among Commission members that involuntary treatment should be the last resort. Indeed, this position is consistent with the least restrictive environment doctrine which is incorporated into Missouri's civil commitment and guardianship laws. With involuntary treatment, the therapist must initially overcome a client's resistance to his/her idea that this treatment is coerced. Effective community intervention before clients decompensate to the point at which inpatient hospitalization is necessary avoids more costly inpatient treatment and encourages voluntary treatment and medication compliance by clients.

Many persons with chronic mental health problems have guardians or limited guardians. These persons often require guardianship because they have treatment or medication compliance problems. Under Missouri guardianship law, wards need not present a "danger to self or others by reason of a mental illness" before involuntary intervention, if necessary, can be invoked. In nature and degree, in many instances the ward's mental health problems are no different from those of individuals for whom no guardians have been appointed.

According to statistics prepared by the State Courts Administrator's Office, 20,072 adult guardianships were pending throughout the state of at the end of Fiscal Year 1994. Although that caseload also includes persons with organic brain syndrome (Alzheimer's disease) and persons with mental retardation, a significant number of the wards have mental illness, e.g., schizophrenia or a bi-polar disorder.

In Missouri, most guardians are family members. However, there are many reasons that family members may not be the best choices to serve as guardians. Public administrators also serve as guardians. Public administrators are appointed as guardians when one or more of the following conditions exist:

1) Conflict of interest between the family member and the proposed ward;
2) Incompatibility or dissension between the family member and the proposed ward;
3) A history of the family member's conduct that indicates that he/she will not act in the proposed ward's best interest;
4) No family member is willing to serve; and
5) No family member can be identified.

Statistics are not available to determine how many of the 20,072 wards have guardians who are public administrators. However, as an example, in Jackson County, the public administrator serves as guardians for nearly half of the 2,786 adult guardianships pending there at the end of Fiscal Year 1994. Assuming that the Jackson County ratio may be higher than elsewhere in the state, it is still clear that a substantial number of wards are served by public administrators.

The Commission is concerned that due to understaffing, shortage of resources, and geographic inaccessibility, many public administrators' offices are unable to provide effective services to incapacitated and disabled wards. With the exception of Jackson, St. Louis, Clay, Platte, Boone and St. Charles counties, expenses of the offices must be paid from fees collected from "asset" estates, yet most wards do not have asset estates. Thus, because of inadequate revenues, public administrators often are unable to employ the staff needed to carry out this responsibility.

If the Access/Crisis Intervention System is to be effectively implemented, public administrator guardians must play a crucial role in maintaining their wards within a voluntary treatment context, placing even greater demands on those offices. A preliminary survey of the guardianship caseload distribution by county, based on the State Court Administrators' statistics, suggests that many public administrators' offices will require additional staff and financial support if the Access/Crisis Intervention System is to operate as intended.

One of the problems the Commission faced in addressing this issue is a lack of data on the distribution of wards with mental illness among public administrators throughout the state. At the Commission's request, the Missouri Association of Public Administrators is conducting a survey to identify the caseload and financial resources of each public administrator's office.

The Association has suggested, and the Commission agrees and recommends, appointment of a separate commission to expand upon the McBride Commission's study of the public administrator system to identify problems and propose solutions to deliver effective services to their mentally incapacitated wards statewide. That separate commission should include public administrators, probate division judges, attorneys regularly involved in the involuntary commitment process, service providers and consumers.

APPENDIX

Resolution and Policy Statement on Advance Directives

RESOLUTION: Be it resolved that the McBride Commission recommends that the Governor appoint a commission, representative of the constituencies that compose Missouri's mental health community, to study the possible adoption and use of mental health advance directives in Missouri.

POLICY STATEMENT: Current Missouri law in Chapters 404 and 459, RSMo provides specific statutory authority and guidelines for utilizing durable powers of attorney for health care and living wills as "advance directives" to guide a person's health care. However, it is not clear that current Missouri statutes also give authority for persons to make "advance directives" for their *psychiatric* health care. To clarify this matter, and, also, to consider providing more legal and services alternatives which may encourage persons to obtain mental health care without having to be subject to civil detention, the McBride Commission urges that the Governor appoint a separate commission to study the possible adoption and use of "mental health advance directives" in Missouri. The composition of this body should reflect the various constituencies in Missouri's mental health community.

APPENDIX

B

Resolution and Policy Statement on Medicaid Managed Care

RESOLUTION: Be it resolved that the McBride Commission strongly recommends that as the State of Missouri pursues the process of establishing and operating Medicaid managed care in Missouri, all contracts that include the provision of behavioral health care services that are negotiated with managed care organizations and providers include specific requirements and standards for how the managed care organizations and providers may be required to provide services to persons subject to involuntary civil detention.

POLICY STATEMENT: Current Missouri law provides that public mental health facilities shall admit persons subject to involuntary civil detention, but private mental health facilities may or may not admit persons who have been civilly detained. The Commission heard testimony, and is concerned, that as non-Department of Mental Health facilities increasingly provide mental health services for persons with mental illness, there have been instances when admission to a private inpatient facility, mental health facility or mental health program for a person covered through some type of "managed care" has been delayed or denied because the managed care organization did not agree to admit the person. Since Missouri is moving to use state funds to contract with managed care organizations and health plans that will be expected to provide mental health care services as a part of their contract with the state, the McBride Commission urges that the state's RFPs and contracts with managed care organizations and health plans specify requirements and standards for how these managed care organizations and health plans and their subcontracting providers and hospitals, mental health facilities, and mental health programs will be required to provide services to persons subject to involuntary civil detention.

APPENDIX

C

Resolution and Policy Statement on Section 630.155 RSMo

RESOLUTION: Be it resolved that the McBride Commission recommends that the Department of Mental Health publish an administrative rule to interpret and implement recommended revisions to Section 630.155.

POLICY STATEMENT: The Commission recommends that the current statute prohibiting client mistreatment, abuse and neglect be extended to cover persons admitted to private mental health facilities and programs. While Department of Mental Health agencies and administrative agents have been implementing the current statute through an internal department operating regulation, extending the statute's coverage to include private mental health facilities and programs requires that a rule be promulgated pursuant to the public notice and comment rule making process.

APPENDIX

The McBride Commission Membership

Lori DeRosear, D.O. *Chairperson*	Psychiatrist and Medical Director, St. Louis State Hospital
John Borron, Jr., J.D.	Judge, Probate Division, Jackson County Circuit Court
Jean Campbell, Ph.D.	Research Assistant Professor in Psychology, Missouri Institute of Mental Health, and Primary consumer
Bert Emmons, M.S.	Executive Director, Archway Communities, Inc., St. Louis
Michael Gunn, J.D.	Attorney and Board of Governors, Missouri Bar and Liaison, Probate and Trust Committee
George Hecker, J.D.	Attorney; Charter Member and First President, National Alliance for the Mentally Ill; Past President, Missouri Coalition of Alliances for the Mentally Ill; and Father of a daughter with mental illness
Leann Jarrett, R.N., M.B.A.	Director of Professional Services, Missouri Hospital Association
Kenny Jones, B.S.	Sheriff, Moniteau County, and President, Missouri Sheriffs' Association
William Kyles, M.A., M.P.A.	Relative of a person with mental illness and President and CEO, Comprehensive Mental Health Services, Kansas City
Joann Leykam, J.D.	St. Charles County Counselor; Former Assistant Attorney General; and Former General Counsel, Department of Mental Health
Robert L. Mark, J.D.	Attorney and Member, Missouri Protection and Advocacy Services Board of Directors

Robert P. McCulloch, J.D.	St. Louis County Prosecuting Attorney and President, Missouri Association of Prosecuting Attorneys
James Moss, M.A.	Relative of a person with mental illness; Former Poplar Bluff City Manager; Historian; and Author
Harold Nance, B.A.	Managing Editor, *Farmington Forum*; Freelance news media writer; President, Missouri Mental Health Consumer Network; and Primary Consumer
Michael Newmark, J.D., M.S.W.	Attorney and Associate Director, Places for People, St. Louis
Larry Pegg, B.S.	Executive Director, Springfield Alliance for the Mentally Ill and Primary Consumer
Barron Pratte, Ph.D.	Chief Executive and Operating Officer, Southeast Missouri Treatment Center, Farmington
Fred Rich, J.D., M.A.	Attorney, Legal Aid of Western Missouri
Ron Rosenauer, B.S.	Buchanan County Public Administrator
David Capehart, J.D., Staff	Assistant General Counsel, Department of Mental Health
John Lyn Turner, M.S., Staff	Director of Patient Admissions, Discharges, and Transfers, Missouri Division of Comprehensive Psychiatric Services

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